# REMARKS

ON

# PLACENTA PRÆVIA,

## WITH A CASE.

BY

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From the Author

With regards

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# REMARKS ON PLACENTA PRÆVIA.

CASE.—On the 3d of January last, I was called to see Mrs L——, æt. 26, residing in No. 12 West Richmond Street, who had been seized with a flooding in the morning while moving about the room. She informed me that she was pregnant with her first child, and that when the discharge began, it was unattended with pain, and was not the result of any physical exertion. On inquiry, I found that she last menstruated the first week of July; she would therefore be about the middle of the sixth month of utero-gestation. I could not well calculate the amount of the hæmorrhage, because part had escaped on the floor; but judging from the woman's account, and what I saw on a towel, there would probably be a few ounces. It was dark and venous-looking.[1] I ordered rest in the horizontal position, a little ice by the mouth, and nutritious diet; and as the flooding had almost ceased, I withheld anything in the shape of astringents. On calling next day, I found there was little more than a few stains on the linen. On the 12th of January, there was another free oozing, and still unaccompanied by pain. Mrs L—— was rather alarmed, and her pulse somewhat quickened, but not feeble. I enjoined a continuance of the previous treatment, with the addition of moderate quantities of wine, and to begin with ɱxxx of the liq. ferri pernit. three times a day after food. Next day the hæmorrhage had much abated, and was almost *nil*. There were discharges after this from time to time—moderate, and less—with intervals of entire cessation, but the flooding always abated to subsidence in the course of from 24 to 48 hours. On the 15th of February, a rather alarming amount came away, and it was retained for my inspection. I found it to consist of dark-looking coagula to the amount of nearly two breakfast cupfuls. Patient said she had still not the slightest pain; but I passed my finger to the os in order to see if it were dilating at all—as gently as possible of course—but it would not admit the point of the finger. I therefore contented myself with ordering a continuance of recumbent rest, nourishing soups, wine, and a persistence with the iron. Things went on in this way until Sunday the 17th of March, when

[1] The blood lost in these cases is generally venous in its character, but it is still an unsettled question whether the hæmorrhage springs from the uterine veins, as Dr Tyler Smith thinks, or through the placental cells and from the openings on the surface of the placenta, according to Sir James Simpson.

a serious flooding took place, accompanied with, or rather preceded by, pain. On my arrival at one o'clock P.M., I found the pains very moderate and slight, but recurring regularly, with a profuse escape of blood. Mrs L—— was pale and agitated, and her pulse was somewhat feeble and frequent. She was, however, cheerful and hopeful, and this condition of mind I endeavoured to foster as an element contributing to her welfare. I gave her two ounces of brandy in a little cool tea. On examination, I found the os dilated to about the size of a florin, but rather rigid and unyielding. I could at once detect the placenta as the presenting part; and by making the finger describe its circumference, I could feel the placenta adherent all round the cervix. Its edge could not be felt in any one direction; no part more attenuated than another could be discovered; and as a matter of course no part of the membranes could be detected. Something bulky and hard could be felt on pressing up the placenta, but I could not be certain, but only conjectured that it was the head. On withdrawing the fingers, they were profusely besmeared with blood, and clots came away from the vagina. I resolved to operate immediately, seeing that the hæmorrhage was considerable on the accession of the pains. Chloroform was administered carefully by Mr Thomson, Nelson Street, who had joined me with Mr Suttie (both intelligent pupils at the New Town Dispensary); and Mrs L—— was brought to the edge of the bed. I then introduced my left hand gradually into the vagina, which (being a primipara) was very much contracted, until I reached the os. Two fingers found entrance; but it took about half-an-hour of semirotatory movement to dilate sufficiently for the whole hand to pass, during which time I had to withdraw it twice or thrice on account of the fatigue occasioned by the compression of the os. Little blood, however, came away during the process. I then, after considerable force, separated—indeed almost tore—a portion of the placenta from the cervix posteriorly (this locality being preferred, as we had fancied we heard the pulsation of the fœtal heart to the left of the middle line), when the membranes began to bulge, and were forthwith ruptured. I felt first the cord, then the head, and lastly reached a foot, and brought it down. The passage of the trunk demanded strong traction; and before the head was got clear of the exceedingly tight os by which it was firmly grasped, ten minutes elapsed, and the funis ceased to pulsate. Fifteen minutes having been occupied with the delivery of the child, and more severe traction being required than I ever remember to have used, with one or two exceptions, and moreover, the cord having ceased to beat, I was prepared to find the child dead, but its heart was felt to pulsate, and I therefore committed it to the care of Mr Suttie, who by the usual means succeeded in restoring it in about half-an-hour. The placenta followed almost immediately, but no unusual flooding. Pressure was exerted over the uterus for a short time, and it con-

tracted pretty well. A drachm and a half of liq. ergotæ was, however, given by way of making "assurance doubly sure." Mrs L—— has gone on well since; and though her pulse is still rather quick and feeble, and she is somewhat blanched-looking, she is (March 24) gaining strength every day. The infant is also doing well.

On inspecting the placenta soon after its delivery, we found it to be, as is common in these cases, thinner and of greater superficial extent than ordinary. It was slightly torn near the edge, where forcibly separated by the fingers, close to the perforation in the membrane.

*Remarks.*—Perhaps I owe an apology for detailing this case at so great length, seeing that there is little of a novel nature either in its history or treatment, but I had a desire to call attention to one or two points connected with the case and the subject generally; besides, a thoroughly successful case of placenta prævia cannot be altogether uninteresting to the obstetrician.

The first point I would direct attention to is the early period at which the hæmorrhage appeared—the middle of the sixth month. On glancing at many recorded cases, I find that the first flooding happened generally somewhat later; but that it should appear so early seems not an unnatural feature to those who believe in the early expansion or distention of the cervix. This early distention, I may just remark in passing, is stoutly denied by such able observers as Weitbrecht, Stoltz, Matthews Duncan,[1] and Cazeau; but I would ask, does not the flooding in placental presentation support the view that it does take place at an early date? And if the cervix is thus expanded, it surely cannot occur without, but must involve a certain amount of development, which is denied by these authors. Of course this difficulty may be got rid of by adopting the view that the growth of the placenta, wherever situated, involves, or provokes, or generates a commensurate increase at the part to which it is attached; and if this be the case, then the early growth of the cervix is an abnormality, and the offspring of another abnormality, viz., the misplaced placenta. Whichever be the correct view—whether early development of the cervix be normal or abnormal—early growth or expansion is in these cases undeniable, and even indispensable, for did it not take place, the placenta would cease to grow: it would become a withered and stunted and blighted thing.

Another point worthy of remark is the long period that elapsed between the first flooding and the advent of labour pains. Is it usual to find the hæmorrhage going on at intervals for ten weeks, without inducing painful uterine contractions? I think not. Is it not rather usually found that the irritation due to the implantation of the afterbirth on the cervix, together with the flooding arising

[1] See article in this Journal for September 1863, by Dr Matthews Duncan, wherein this subject is very ably discussed and illustrated.

from its detachment, tend to excite the uterus, and to precipitate labour a considerable time before the full period of pregnancy? It did induce it prematurely in this case (a month before the full time), but not at so early a period as I should have looked for.

*Treatment.*—Turning now to the treatment, it will be observed that I adopted the plan usually followed when practicable; at the same time I confess that the introduction of my fingers into the os, while a necessary preliminary, was also a tentative proceeding in this case. It was tentative, because I did not know precisely the condition of the placenta; that is to say, whether it was firmly attached to its site or not. Had I found it severed to any considerable extent—loosened from its connexion with the cervix so much that there was no chance of the child deriving benefit from it—I should have preferred removing it, as the first step.[1] I should also have unhesitatingly followed Sir James Simpson's line of treatment, had I had to deal with exceedingly profuse flooding, a profoundly exhausted patient, or where turning was inadmissible from this prostration, or from other causes, such as a too contracted condition of the pelvis or a tetanic state of the womb. If the child had been dead or non-viable, I should also have made the third stage precede instead of follow the delivery of the child. These conditions I need hardly say often obtain and imperatively demand the treatment indicated. None of them, however, existed in the case under review; therefore I resolved to separate a portion of the placenta and go in quest of a leg. This is the best method where there is but moderate hæmorrhage, a living child, a mother *not* at death's door, a fair prospect of version, and an unloosened placenta. Its advantages are several. You expedite labour, you arrest the bleeding, you do not necessarily destroy, but offer a chance of life to the child. By this method alone have you a fair prospect of rescuing the infant, as well as its mother, from the gaping jaws of death! But if the placenta be pretty firmly adherent round and round, and not very easily separated, and no thin portion be felt towards the edge, would it not be a better plan to tunnel right through it with the fingers, and thus reach the foot of the child? I do not think so. It is a plan that has few supporters, and I heartily join the majority in condemning it. It is true that Mohrenheim[2] and a few others recommended it, and Smellie[3] too once practised it, but it was more from a kind of doubtful necessity than choice. Its advantages are *nil*, while its dangers are more than one, and its difficulties not inconsiderable. Take the latter first. You may find the perforation of it, like the opening up of Japan or the North-west Passage (if we may compare small things with great), by no means

[1] This method was adopted in such cases by Guillemeau (Œuvres de Chirurgie, p. 320); by Mauriceau (Maladies des Femmes Grosses, tom. i., p. 333); and by Daventer and Pugh. Dr Radford advises it in similar cases.

[2] Praxis Medico-obstetrica Mosquæ, 1810, p. 176.

[3] Case 8, No. 2, collect. 33.

an easy matter. For example, in pushing up the fingers and applying force, the placenta, as I have found, instead of giving way, resiles, there being no counter-force—no resistance behind—nothing beyond that which it is enabled to offer as the result of its attachment to the cervix; you merely indent and extend it a bit, instead of tearing it through. The same thing often happens (and the analogy is suitable and striking) with the bag of membranes; for do we not often find these, though highly attenuated—though vastly thinner—resisting our attempts to perforate them with the finger, until the force of the water behind helps us to effect the rupture? Of course, a soft and friable afterbirth will be more easily penetrated.

Take now the dangers. These are by no means light. Instead of perforating, you may push up the entire placental mass; or, if you force your successful way, the aperture may be too contracted for the child easily to pass; or, again, you may tear extensively the placental vessels; and in either case, not to speak of maternal risk, the result is the exposure of the child to certain peril, and almost to certain death. The sweetness, therefore, said to spring from the saving of a life, is likely to be exchanged for the unwholesome bitterness inseparable from the losing of it in a case where loss was certainly not inevitable. I would disapprove of this plan, therefore, and only adopt it if driven to it (like the tempest-tossed vessel going to the nearest port), which misfortune can happen to us but seldom indeed—can happen to us only, in fact, if we fail to separate the placenta, or part of it rather, from its attachment to the cervix.

*The Mother.*—Coming now to the mother, who happily made a good recovery in the sense of rallying well from debility and having no untoward after-symptoms, while not pretending to claim credit for this, I may yet be pardoned for speculating briefly on the probable causes of her welldoing. During the ten weeks of her hæmorrhagic history she lost a good deal of blood, yet at the end of this period—that is, up to the commencement of labour—she was not reduced to very great feebleness, though she certainly was somewhat blanched-looking, and felt faint and giddy at times. Her pulse was not very firm, but it was not strikingly frequent. For a few days after the discharge she was a good deal prostrated, but she rallied again before a renewal of the flooding. I would simply ask, then, under this head, how much might be due to the dietetic treatment—the soups and the wine, etc.—and how much to the iron? The question is doubtless more easily put than answered, for in cases of this nature we cannot altogether eliminate conjecture. I for one, however, lay stress on the iron (and my patient was certainly well plied with it); it is a blood-making medicine emphatically, and, as we often see in anæmic cases, brings back in a few weeks the ruddy glow to the blanched and pallid cheek. There is an obvious caution in connexion with its use, viz., to obviate its constipating effect, every few days, with gentle laxatives, as straining

at stool almost infallibly renews the flooding. It will be observed that the preparation employed was the pernitrate. This is doubtless the most suitable, for while tonic it is also one of our most reliable astringents, and by selecting it we are enabled to dispense with the other medicinal hæmostatics, such as gallic acid, tannic acid, and acetate of lead, which, though excellent astringents in many cases, often impair the tone of the alimentary canal, and render the patient unable to partake of those nutritious foods which are so essential in cases of this nature, or to assimilate them if taken. Yes, their use —the use of those astringents which are not tonics—may be said to be an abuse, for by them, while bestowing benefit, you entail also evil,—evil which it is to be feared outweighs the good.

But, further, while it was of the utmost importance in this case to stimulate highly in the afore-named way, medicinally and dietetically, with the view of repairing waste, of replacing lost blood, guarding at the same time against undue stimulation when the flooding was going on, it was of no less moment to act decisively and promptly when labour pains supervened, for then was the most critical time. This I think it will be seen was done, and with the best result; and here I should like to make a remark or two on the treatment to be adopted at this stage—the preliminary treatment, so to speak—that which, as a rule, these cases being generally premature, we have to face or encounter before the turning or the removal of the placenta, whichever treatment we elect can be proceeded with. Well, then, hæmorrhage is going on and increasing with every recurrent pain, until a scant enough supply mayhap is left for the maintenance of the cardinal vital acts, and yet the os remains rigid. Entrance must be had with a view to efficient action, yet a gateway, so to speak, interposes, and bars admission. What, then, is to be done? Shall we apply the tampon and wait, or tunnel our gradual and cautious, yet persistent way, until the os dilates so as to admit the hand? I incline to the latter plan, and would recommend it. It was thoroughly successful in this case, and one or two others that have come under my observation. Some authorities in London—where they were as long a period in understanding or appreciating chloroform as the siege of Troy lasted, if they yet thoroughly apprehend it—some gentlemen there, and over in the capital of the verdant isle, and in other places, are very chary about fingering the os;[1] they are almost as much afraid to handle it as the rustic was to cherish the frozen viper, or as some of our surgeons are to try the needle instead of the thread in arterial bleeding. They say that it is fraught with danger, and clinch the statement with the threadbare aphorism (profoundly true in some circumstances and cases) that "a meddlesome midwifery is bad." Now, with all respect for these oracles, who are certainly less ambiguous

[1] "Almost all the English authorities, Dr Collins and all the Irish, object to digital interference for the purpose of dilating the cervix." (See Churchill's Midwifery, 4th ed., p. 252.)

than the ancient ones, I must say that I think the evils of manual dilatation have been overrated, and that the dangers so gloomily portrayed are nothing more substantial or less impalpable than the play of the fancy. Sanctioned by such a trustworthy trio as Smellie and Burns and Hamilton, men renowned and not often rivalled for practical skill, and supported by the *dii majores* of the Edinburgh school, and warranted by a now not very limited experience, I have dilated the rigid os with my fingers often when antimony and opium, and belladonna and the anæsthetic, and steaming had all failed, and even in truth not seldom without trying these relaxants, and I cannot recal a single untoward symptom as having sprung from the interference, but, on the contrary, I can reckon up incalculable good. We have now, I think, ceased to view the practice as dangerous, as we have ceased to consider with Hippocrates that wounds of membranous parts are necessarily mortal, and simply because we have profited by the plain teachings of experience. As the result, few of us, I rather think, hesitate much to handle the anterior lip when it is any way refractory, and even the posterior for that matter, if called for, and thereby, I am fully convinced, not aggravating, but abbreviating the suffering of the mother. Much more in placenta prævia is this interference necessary, for here

"It is the chief
Of all perfections to be somewhat brief."

But a word may be said in reference to the nature of the interference, which has doubtless been misapprehended by some. By manual dilatation we do not mean a forcible distention, even at the risk of laceration, but a gradual and persistent, though alternating pressure on the os, in order to wear out or fatigue its muscular fibres, and thereby to induce that relaxation of which it possesses the power as much as it does that of contraction. The kind of interference may in fact be likened to that of the besieging army which (whether animated by a merciful spirit or not) prefers wearing out the garrison by an occasional shot, rather than forcing a reckless and ruinous way through the walls of the citadel, and battering both it and its occupants to the dust. In this case I might have forced my hand into the uterus in the course of a few minutes, but I preferred the safer method which occupied half-an-hour.

Set about the dilatation of the os, then, I would say, whenever the labour pains begin, at the very latest,—earlier if there be a perfect cataclysm of blood; do it cautiously, but yet somewhat firmly and perseveringly, and an effectual entrance will gradually be achieved, unpurchased by pain or peril;—free from pain because chloroform is present, and safe from risk because we stop short of laceration. But may there not be a chance of inflammation being excited by this? The cervix is said by the Bennets and the Tilts to be very prone to this even when let alone,—almost

as prone to run into the hyperæmic state as a modest maiden is to blush, or a cherry to redden in summer,—and it certainly has not been dipt, like Achilles, into any charmed stream to make it invulnerable. But yet, as before said, we find it, at least in the normally developed or gravid state, wonderfully tolerant of a long and liberal handling; and surely, too, the soft, gentle, and well-belarded fingers going up cannot be more calculated to injure than the hard head coming down, which descent is sometimes so impetuous and forcible as to lacerate the cervix, or even tear away a portion of the uterus itself;[1] the womb being thus its own destroyer—committing *felo de se.* Of course, when nature performs a painful prank of this kind, there is no one to blame; it is all right, and at the same time all wrong.

There is another thing to be noticed in connexion with this dilating process, viz., that, contrary to what might be expected, little blood is lost during its performance, the hand, as has been pointed out by different observers, proving a pretty effectual tampon of itself.[2]

*The Tampon.*—But now about the plug; what is its true worth and value in these cases? Will it arrest the hæmorrhage effectually and entirely? Certainly, we may stuff the vagina as full as an egg, plug it so securely with sponge or cotton wool that no blood may flow externally, but will internal bleeding be thus prevented? I suspect not.[3] The reason is this, that the uterus is never, even at the full time, entirely filled by the ovum, but, on the contrary, room and verge exists and is created sufficient to contain an amount of blood fitted almost to prove fatal. Plugging, then, is not a very reliable plan here, so far as the conservation of blood is concerned—which is indeed the paramount concern; and in resorting to it, it is to be feared, we perpetrate something not unlike the folly of the ostrich when she plunges her head in the sand; we merely hide from our vision the danger that besets us. Yes; we shut out from our view the bleeding that is going on,—a discharge that, of course,

[1] Cases of this kind are reported by Dr E. Kennedy, Dr Davis, Dr Johnston, and others.

[2] "By the pressure it exerts on the open vessels."—*Ramsb.*

[3] Dr Ramsbotham says, in his work (Obst. Med. and Surg., p. 414), "that by using the plug much blood may be collected within the cavity of the womb, even to the induction of a fatal termination."

Merriman (Synopsis, p. 127) says he thinks the plug ought not to be used when the bulk of the uterus exceeds that of a pregnancy of three or four months.

Gardien (Traité des Accouchmens, tom. ii., p. 419) also objects to the plug; as did also Dr Hamilton. In Dr Lees' Clinical Midwifery, several cases are related where the plug was employed,—for example, cases 43 and 58, but without success, or, in other words, without saving blood. Dr L. in many cases also, instead of waiting for the dilatation of the os, chose rather to perform craniotomy! I for one would certainly work hard at manual dilatation before resorting to this extreme, which, however, may have frequently saved the mother's life.

would be even more impressive and striking and suggestive in its outflow than in its results, such as the blanched countenance and the feeble pulse.

I have heard some gentlemen, who do not trust it much as a means of arresting hæmorrhage, allege that it is useful in stimulating the uterus—in provoking labour pains! Now, this, in my estimation, so far from being an advantage or recommendation, is another ground for condemning it. We do not in these cases desiderate uterine contraction; passivity more than activity of the womb is desired. The reason is plain. Uterine contraction here involves loss of blood, and blood is what we wish to save. Nay, more; I will say that uterine action not only subjects the enfeebled patient to a process of blood-letting, but is an obstacle to delivery. This may seem paradoxical, but is as obvious as the preceding statement; for we do not in the majority of these cases rely on the womb at all, but take the delivery into our own hands; and in the accomplishment of it a contracting uterus will oppose us much, and is what we may pray to be delivered from. But further, granting that the plug did stem the weakening tide to some extent, it would by no means follow that relaxation of the os would be induced; for if the case were premature (and most of them are), then it would be premature to expect dilatation without some force. Flooding does not always or readily soften in premature cases, nor when the organ is to a greater or less extent undeveloped, as we see in abortions and polypi,—where, I need hardly add, in the one case we have often much trouble in hooking down part or whole of the blighted ovum; and where, in the other, we have no less toil in landing a fibroid, even when it is detached from the uterine wall. The plug, then, may remain in for a considerable time, and yet on its removal the work of dilatation may after all have to be begun. Much time is thus lost, and time here is blood; and blood, if not life itself, according to the old view, is one of the prime essentials of its existence. The plug, then, I repeat in conclusion, has little of worth wherewith to win our suffrage; its little good is outweighed by greater evil. In other words, if by it you save a trifle of blood, by it you sacrifice even more, and lose also inestimable time; and time in such a case, as before said, is almost convertible with blood, and blood almost equivalent to life. Temporise not with it—delay not by means of it; for by doing so you may lose your patient's life!

*The Child.*—In connexion with the child there are one or two points I think worthy of remark. First, it did not seem to have suffered much by the mother's loss, by part of the vital stream being deflected and escaping externally; for though premature, and therefore smaller, it was neither lean nor shrivelled or puckered, but plump. It follows, therefore, that though the area of supply was more and more circumscribed by the repeated separation of parts of the placenta, by a compensating process, probably increased

activity or augmented calibre of the remaining channels of communication, the necessary amount of blood was sent on. Thus we have another evidence of the resources, of the adaptive power of Nature; for she is full of wonders, and needs not the eloquent but fanciful additions of a Goldsmith or a Chaillu in order to awaken both our admiration and our awe.

Secondly, I would call attention to the escape of the infant. Without claiming any credit for it, I venture to say that it was something wonderful. The time occupied in delivery after the leg was seized (owing to the rigidity and contraction of the uterus), was about fifteen minutes, and the cord could not escape severe compression. I have lost one or two children in much less time, where much less force was required, and though bestowing much pains on the funis, trying to relieve it from compression. The extractive force was also very great; for the limbs cracked as they were brought down, as did also the inferior maxilla as I endeavoured by means of the finger in the mouth to get the head cleared of the tightly-engirding os. The immunity of the child, under these circumstances, impels me to a reiteration of a statement I ventured to make in this place on a former occasion, viz., that it is truly surprising what an amount of traction the little ones will bear with impunity,—not only escaping with life, but even often apparently without lesion. At the same time, there must be a limit to their power of endurance, beyond which danger is inevitable, and within which it will be a pleasant thing for us if we can remain.

Lastly, a word in reference to the cord. Pulsation in it had ceased for a minute or two, but the circulation must have being going on. The fœtal heart had been acting, although there was no indication of this in the funis. Absence of pulsation in the cord, therefore, does not necessarily indicate death, which can only be declared to have taken place when respiration and cardiac pulsation have both ceased. The heart may be acting although there be no manifestation of this in the funis; but when this state of matters exists, it must forbode the speedy extinction of life.

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